Why You Should Read This Booklet

Sooner or later, nearly everyone will be affected by Medicare, the nation's major federal health insurance program. In fact, if you pay taxes, you're already affected by Medicare because a portion of your taxes goes to finance part of the Medicare program.

Even though you're paying into the Medicare program during your working years, and will probably rely on its services in the future, you may not be aware of what benefits the program offers—and what it doesn't offer. The basic information in this booklet will give you an overview of the Medicare program. If you want detailed information or are interested in a specific part of the program, you'll need to get a copy of *Your Medicare Handbook*, published by the Health Care Financing Administration. The *Handbook* is mailed to Medicare beneficiaries when they become eligible for the coverage. See Section 7 for information about ordering the *Handbook* and other publications.

> **Please Note:** This booklet does not list premium amounts, deductibles, coinsurance payments, and other figures that change every year. For the most up-to-date information about these numbers, ask Social Security for a copy of the factsheet *Social Security Update* (SSA Publication No. 05-10003).

What's Inside

Section 1—What Is Medicare?

Medicare is our country's health insurance program for people age 65 or older, certain people with disabilities who are under 65, and people of any age who have permanent kidney failure. It provides basic protection against the cost of health care, but it doesn't cover all your medical expenses nor the cost of most long-term care. You can choose one of two ways to get benefits under Medicare: the traditional fee-for-service system or the managed care program. To help you decide which way is best for you, read the descriptions in Section 5, page 14.

The Health Care Financing Administration is the agency in charge of the Medicare program. But we—the people at the Social Security offices—help you enroll in the program and give you general Medicare information.

Medicare Has Two Parts

There are two parts of Medicare. They are:

Hospital Insurance (also called "Part A" Medicare), which is financed by a portion of your payroll (FICA) tax that also pays for Social Security; and

Medical Insurance (also called "Part B" Medicare), which is partly financed by monthly premiums paid by people who choose to enroll.

You are automatically enrolled in Part B when you become entitled to Part A. However, because you must pay a monthly premium for Part B coverage, you have the option of paying for the coverage or turning it down.

Each part of Medicare covers different kinds of medical costs, has different rules about enrolling, and so on. Because of these differences, the two parts of the Medicare program are described separately in many sections of this booklet.

A Word About Medicaid

Many people think that Medicaid and Medicare are two different names for the same program. Actually, they are two different programs. Medicaid is a state-run program designed primarily to help those with low income and little or no resources. The federal government helps pay for Medicaid, but each state has its own rules about who is eligible and what is covered under Medicaid. Some people qualify for both Medicare and Medicaid. For more information about the Medicaid program, contact your local social service or welfare office.

Section 2—Who Can Get Medicare And How To Sign Up

Hospital Insurance

If You Are 65 or Older

Most people 65 or older are eligible for Medicare hospital insurance (Part A) based on their own—or their spouse's—employment. You are eligible at 65 if you:

- receive Social Security or railroad retirement benefits, **or**
- are not getting Social Security or railroad retirement benefits, but you have worked long enough to be eligible for them, **or**

- would be entitled to Social Security benefits based on your spouse's (or divorced spouse's) work record, **and** that spouse is at least 62 (your spouse does not have to apply for benefits in order for you to be eligible based on your spouse's work) **or**,
- worked long enough in a federal, state, or local government job to be insured for Medicare.

If You Are Under 65

Before age 65, you are eligible for Medicare hospital insurance if you:

- have been a Social Security disability beneficiary for 24 months, **or**
- have worked long enough in a federal, state, or local government job **and** you meet the requirements of the Social Security disability program.

If you receive a disability annuity from the Railroad Retirement Board, you will be eligible for hospital insurance after a waiting period. (Contact your railroad retirement office for details.)

Eligibility For Family Members

Under certain conditions, your spouse, divorced spouse, widow or widower, or a dependent parent may be eligible for hospital insurance when he or she turns 65, based on your work record.

Also, disabled widows and widowers under age 65, disabled divorced widows and widowers under 65, and disabled children may be eligible for Medicare, usually after a 24-month qualifying period. (For disabled widows/widowers, previous months of eligibility for Supplemental Security Income (SSI) based on disability may count toward the qualifying period.)

If You Have Kidney Failure

There are special rules for people with permanent kidney failure. Under these rules, you are eligible for hospital insurance **at any age** if you receive maintenance dialysis or a kidney transplant **and**:

- you are insured or are getting monthly benefits under Social Security or the railroad retirement system, **or**
- you have worked long enough in government to be insured for Medicare.

In addition, your spouse or child may be eligible, based on your work record, if she or he receives continuing dialysis for permanent kidney failure or had a kidney transplant, even if no one else in the family is getting Medicare.

If You Do Not Qualify Under These Rules

Certain aged or disabled people who do not qualify for Medicare hospital insurance under these rules may be able to get it by paying a monthly premium.

Medicare Medical Insurance

Almost anyone who is 65 or older—or who is under 65 but eligible for hospital insurance—can enroll for Medicare medical insurance by paying a monthly premium. You don't need any Social Security or government work credits for this part of Medicare.

Aliens who are 65 or older and are not eligible for hospital insurance must be lawfully admitted permanent residents and must live in the United States for five years before they can enroll for medical insurance.

Help For Low-Income Medicare Beneficiaries

If your income and assets are very limited, you should know about programs that can help save you money. One is the "Qualified Medicare Beneficiary" or "QMB" program. The other is the "Specified Low-Income Medicare Beneficiary" or "SLMB" program. Both programs are run by the Health Care Financing Administration and the state agency that provides medical assistance under the Medicaid program. They differ in the amount of income that qualifies you for help.

If you qualify for the QMB program, your state will pay your monthly Medicare premiums. You will not have to pay the Medicare deductibles and coinsurance, which can save you **a lot** more money. If you qualify for the SLMB program, your state will pay only your medical insurance (Part B) monthly premium.

The rules vary from state to state. In general, you may qualify for help from the QMB or SLMB program if:

- **your income is limited; and**
- **your "resources" do not exceed certain limitations.** (Resources are things you own. But some things don't count. For example, the house you live in and some other things, such as a car, may not count.)

Only your state can decide if you qualify for help under the QMB or SLMB program. To find out if you qualify, contact your state or local medical assistance (Medicaid) agency, social service office, or welfare office. For general information, ask Social Security for a copy of the leaflet *Medicare: Savings for Qualified Beneficiaries* (Publication No. HCFA 02184).

Signing Up For Medicare

If you're already getting Social Security retirement or disability benefits or railroad retirement checks, we'll contact you a few months before you become eligible for Medicare and give you the information you need to sign up.

If you aren't already getting checks, you should contact us about three months before your 65th birthday to sign up for Medicare. You can sign up for Medicare even if you don't plan to retire at 65.

You should contact Social Security about applying for Medicare if:

- you're a disabled widow or widower between 50 and 65 but haven't applied for disability benefits because you're already getting another kind of Social Security benefit;
- you're a government employee and became disabled before 65;
- you, your spouse, or your dependent child has permanent kidney failure;
- you had Medicare medical insurance in the past but dropped the coverage; or
- you turned down Medicare medical insurance when you became entitled to hospital insurance.

Initially, you have seven months to sign up for medical insurance (Medicare Part B). This seven-month period begins three months before your 65th birthday, includes the month you turn 65, and ends three months after that birthday. If you enroll during the first three months of your enrollment period, your medical insurance protection will start with the month you are eligible. If you enroll during the last four months, your protection will

start one to three months after you enroll. If you don't enroll during this initial enrollment period, each year you are given another chance to sign up during a general enrollment period from January 1 through March 31. Your coverage begins the following July. Your monthly premium increases 10 percent for each 12-month period you were eligible but didn't enroll.

If you're 65 or older and don't qualify for Medicare, you can buy Part A coverage, much like private insurance, for a monthly premium. If you want to buy Part A hospital insurance, you must enroll in Part B and pay a monthly premium for that coverage as well. If you wait to buy Part A hospital insurance, the enrollment periods are the same as those for Part B, discussed above.

Section 3—What Medicare Covers

The two parts of Medicare are designed to help pay for different kinds of health care costs. Some kinds of health care aren't covered by Medicare at all. You can get specific information about Medicare costs, deductibles, and "coinsurance" rates by calling Social Security.

Medicare Hospital Insurance

Medicare hospital insurance can help pay for inpatient care in a hospital or skilled nursing facility following a hospital stay, home health care, and hospice care. Except for home health care, each is subject to a benefit period, which measures your use of services covered by Medicare Part A.

A benefit period starts the day you enter a hospital. It ends when you have been out of the hospital or other facility primarily providing skilled care for 60 days in a row. If you remain in such a facility (other than a hospital), a

benefit period ends when you have not received any skilled care there for 60 days in a row. There is no limit to the number of benefit periods for hospital and skilled nursing facility care. But special limits do apply to hospice care. (See "Hospice Care," page 12.)

Inpatient Hospital Care

If you need inpatient care, hospital insurance helps pay for up to 90 days in any Medicare-participating hospital during each benefit period. Hospital insurance pays for all covered services for the first 60 days, **except for a deductible**. For days 61 through 90, hospital insurance pays for all "covered services" **except for a daily coinsurance amount**. (Coinsurance is the portion of the bill that the beneficiary is required to pay even after the deductible is met.)

If you are out of the hospital for at least 60 days in a row, and then go back in, a new benefit period begins—your 90 days of coverage starts all over again and you pay another deductible.

What if you need more than 90 days of inpatient care during any benefit period? You can use some or all of your "reserve days." Reserve days are an extra 60 hospital days you can use if your illness keeps you in the hospital for more than 90 days. You have **only** 60 reserve days in your lifetime, and you decide when you want to use them. For each reserve day you use, hospital insurance pays for all covered services **except for a daily coinsurance amount.**

Skilled Nursing Facility Care

If you need inpatient skilled nursing or rehabilitation services after a hospital stay and you meet certain other conditions, hospital insurance helps pay for up to 100 days in a Medicare-participating skilled nursing facility in each benefit period.

Hospital insurance pays for all covered services for the first 20 days. For the next 80 days, it pays for all covered services **except for a daily coinsurance amount**.

> ***NOTE:*** It is important to know that Medicare does **not** pay for "custodial care" when that is the only kind of care that you need. Custodial care is the type of care many people receive in nursing homes. It is care that **could** be given by someone who is not medically skilled (for example, help with dressing, walking, or eating).

Home Health Care

If you are confined at home and meet certain other conditions, Medicare can pay the full approved cost of home health visits from a Medicare-participating home health agency. There is no limit to the number of covered visits you can have.

If you need one or more of the covered services, then hospital insurance also covers part-time or intermittent services of home health aides, occupational therapy, physical therapy, medical social services, and medical supplies and equipment. A 20-percent copayment applies to covered durable medical equipment (e.g., wheelchairs and hospital beds).

Hospice Care

A hospice program provides pain relief and other support services for terminally ill people. Medicare hospital insurance can help pay for hospice care for terminally ill beneficiaries if the care is provided by a Medicare-certified hospice and certain other conditions are met.

Special "benefit periods" apply to hospice care. Hospital insurance can pay for hospice care for a maximum of two 90-day periods and one 30-day period and one extension period of indefinite duration when the patient is terminally ill.

Medical Insurance Benefits

Medicare medical insurance helps pay for doctor's services and many medical services and supplies that are not covered by the hospital insurance part of Medicare, such as ambulance services, outpatient hospital care, and X-rays.

Deductible

Each year, before Medicare medical insurance begins paying for covered services, you must meet the annual medical insurance "deductible." (A deductible is the amount a beneficiary must pay before Medicare begins paying.) After you meet that deductible, Medicare will generally pay 80 percent of the approved charges for covered services during the rest of the year.

Section 4—What Medicare Does Not Cover

Medicare provides basic health care coverage, but it doesn't pay all of your medical expenses. Here are examples of what Medicare does **not** pay for:

- "custodial care" (This is care that **could** be given safely and reasonably by a person who is not medically skilled and that is given mainly to help the patient with daily living. Examples include help with walking, bathing, and dressing. Even if you are in a participating hospital or skilled nursing facility, or you are getting care from a participating home health agency, Medicare does **not** cover the cost of care if it is mainly custodial.)
- most nursing home care
- dental care and dentures
- routine checkups and the tests directly related to these checkups (except that some screening, Pap smears, and mammograms are covered)
- most immunization shots (except Part B helps pay for flu and pneumonia shots)
- most prescription drugs
- routine foot care
- services outside the United States
- tests for, and the cost of, eyeglasses or hearing aids and
- personal comfort items, such as a phone or TV in your hospital room

Section 5—Medicare Options

Medicare beneficiaries may now choose how they'll receive hospital, doctor, and other health care services covered by the program. And, your choice may affect the amount of money you pay for these services.

Most people use the traditional "fee-for-service" delivery system—visiting the hospital or doctor of their choice and paying a fee each time they use a service. But more and more people are turning to health maintenance organizations (HMOs) that feature comprehensive coverage of services offered by a network of health care providers. Medicare coverage is the same under both systems. The differences include how the benefits are delivered, how and when payment is made, and the amount of "out-of-pocket" expenses required.

Fee-For-Service Systems

Under fee-for-service systems, Medicare pays a set percentage of a beneficiary's hospital, doctor, and other health care expenses, and the beneficiary is responsible for certain deductibles and coinsurance payments (the portion of the bill Medicare does not pay). Most people covered under a "fee-for-service" Medicare plan also purchase private insurance—usually called "Medigap"—or have retiree coverage available from their former employer or union to supplement their Medicare coverage (see Page 16–17).

Health Maintenance Organizations (HMOs)

HMOs that have contracts with the Medicare program must provide all hospital and medical benefits covered by Medicare. However, usually you must obtain services from your HMO's network of health care providers (doctors, hospitals, skilled nursing facilities, for example). In most cases, for services not authorized by your HMO (except emergency services or services urgently required while you are out of the HMO's service area) neither the HMO nor Medicare will pay for these services.

If you enroll in an HMO that has a contract with Medicare, the HMO will receive a monthly payment from Medicare, and you will have to enroll in Medicare Part B and continue to pay your Part B monthly premium. Most HMOs charge a monthly premium for enrollees in addition to a small copayment each time you use a service. Usually, no additional charges are made no matter how many times you visit the doctor, are hospitalized, or use other covered services. HMO members usually do **not** need a Medigap policy.

Many HMOs that have contracts with the Medicare program also provide benefits beyond those Medicare pays for. These include preventive care, prescription drugs, dental care, hearing aids, and eyeglasses. The benefits may vary by HMO and you'll need to read the individual descriptions to determine which benefits are offered by each.

What If You Think You Need More Insurance?

Traditional "fee-for-service" Medicare coverage provides basic health care coverage, but it can't pay all of your medical expenses, and it doesn't pay for most long-term care. For this reason, many private insurance companies sell insurance to fill in the gaps in Medicare coverage. This kind of insurance is often called "Medigap" for short. However, Medigap insurance is not needed if you use an HMO (see Page 14).

The Health Care Financing Administration publishes a booklet with information on supplementing Medicare coverage. It's called *Guide To Health Insurance For People With Medicare* (Publication No. HCFA 02110) and is available from any Social Security office or by writing to: Medicare Publications, Health Care Financing Administration, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

Section 6—What You Should Know If You Have Other Health Insurance

As we've explained, Medicare hospital insurance is free, but you pay a monthly premium for medical insurance. If you already have other health insurance when you become eligible for Medicare, is it worth the monthly premium cost to sign up for Medicare medical insurance?

The answer varies with the individual, and the kind of other health insurance. Although we can't give you "yes" or "no" answers, we can offer a few tips that may be helpful when you make your decision.

If You Have A Private Insurance Plan

Get in touch with your insurance agent to see how your private plan fits—or "integrates"—with Medicare medical insurance. This is especially important if you have family members who are covered under the same policy. And remember, just as Medicare doesn't cover all health services, most private plans don't either. In planning your health insurance coverage, keep in mind that most nursing home care is not covered by Medicare or private health insurance policies. One important word of caution: For your own protection, **don't cancel any health insurance you now have until your Medicare coverage actually begins**.

If You Have Health Insurance From An Employer Group Health Plan

In this case, there are some special rules you should know about.

If you are age 65 or older and are (a) currently employed or (b) married to an individual of any age who is currently employed, **and** are covered under a group health plan, you may delay enrolling in Medicare medical insurance (Part B) and enroll during a special enrollment period. The rules allow you to enroll any time while you are covered under the group health plan or during a special eight-month period that begins with the month your group health coverage ends or the month employment ends —whichever comes first. If you meet the requirements, you may not have to wait for a general enrollment period and you may not have to pay the 10-percent premium surcharge for late enrollment in Medicare. If however, the coverage or employment ends during the last four months of the initial enrollment

period and you enroll for Medicare medical insurance uring this period, protection will be delayed one to three months (see Page 8).

Group health plans of employers with 20 or more employees are required by law to offer workers who are 65 (or older) the same health benefits that are provided to younger employees. They must also offer the spouses who are 65 (or older)—of workers of any age—the same health benefits given younger spouses.

If you are 65 or older and have current employment—or you are 65 or older and are the spouse of a person who has current employment—and you accept the employer's health insurance plan, Medicare will be the **"secondary payer."** This means the employer plan pays first on your hospital and medical bills. If the employer plan does not pay all of your expenses, Medicare may pay secondary benefits.

If you reject the employer's health plan, Medicare will be the primary health insurance payer. The employer is **not** allowed to offer you Medicare supplemental coverage if you reject his or her health plan.

Remember that when you enroll in Medicare Part B at or after age 65, you will trigger your one-time Medigap open enrollment period. If you enroll in Part B while you are covered under an employer plan that is the primary payer, you may not need a Medigap policy. Your Medicare Part B will be the secondary payer and your employer will be the primary payer. Later, when you are no longer covered by your employer plan, you may not be able to purchase the Medigap plan of your choice because your Medigap open enrollment period will have expired.

If on the other hand, you delay Part B enrollment until your primary employer plan coverage is about to stop, you will be able to use your open enrollment period to your

best advantage. During open enrollment, you may purchase any Medigap plan from any company at its most favorable price for your age group. During this period, you can purchase policies that cover outpatient prescription drugs, which generally are not available outside of the open enrollment period unless you are healthy.

If you are under 65 and disabled, and you are currently employed or are the family member of a person who has current employment and you have health coverage under a "large group health plan," Medicare will be the secondary payer. A large group health plan covers employees of an employer or group of employers of which at least one employer has 100 or more workers. If that's the case, you will also have special enrollment period and premium rights that are similar to those for workers 65 or older.

If you are entitled to Medicare because of permanent kidney failure and you have employer group health coverage, Medicare will be the secondary payer for the first 18 months of your Medicare Part A eligibility or entitlement. At the end of the 18-month period, Medicare becomes your primary payer.

If You Have Health Care Protection From Other Plans

If you have coverage under a CHAMPUS or CHAMPVA program, your health benefits may change or end when you become eligible for Medicare. You should contact the Department of Defense or a military health benefits advisor for information before you decide whether or not to enroll in Medicare medical insurance.

If you have health care protection from the Indian Health Service, Department of Veterans Affairs (DVA), or a state medical assistance program, contact the people in those offices to help you decide whether it is to your advantage to have Medicare medical insurance.

Questions?

We've covered a number of difficult rules in this section. If you aren't sure if any apply to you, contact Social Security for help. (But if you aren't sure about the size of the employer group health plan, check with the personnel office or the employer.)

Section 7—Want More Information?

It's difficult to summarize a program as complex as Medicare in a single booklet. If you have other questions about Medicare, please contact Social Security.

You can get more information 24 hours a day by calling Social Security's toll-free number: **1-800-772-1213**. You can speak to a service representative between the hours of 7 a.m. and 7 p.m. on business days. Our lines are busiest early in the week and early in the month so, if your business can wait, it's best to call at other times. Whenever you call, have your Social Security number handy.

If you have a touch-tone phone, recorded information and services are available 24 hours a day, including weekends and holidays.

People who are deaf or hard of hearing may call our toll-free "TTY" number, 1-800-325-0778, between 7 a.m. and 7 p.m. on business days.

The Social Security Administration treats all calls confidentially — whether they're made to our toll-free numbers or to one of our local offices. That's one reason why if you've asked someone to call our office for you to discuss your personal business, you need to be with them when they call so we can verify you want their help. Our representative will ask your permission to discuss your business. We also want to make sure that you receive accurate and courteous service. That's why we have a second Social Security representative monitor some incoming and outgoing telephone calls.

Other Publications Available

The Social Security Administration produces many other publications and factsheets to give you information about other parts of the Social Security program. You can get a free copy of these publications from any Social Security office. Here's a list of some of the publications we have available.

- *Social Security—Understanding The Benefits* (SSA Publication No. 05-10024)—A brief overview of each of the Social Security programs
- *Social Security—Retirement Benefits* (SSA Publication No. 05-10035)—A guide to Social Security retirement benefits

- *Social Security—Disability Benefits* (SSA Publication No. 05-10029)—A guide to Social Security disability benefits
- *Social Security—SurvivorsBenefits* (SSA Publication No. 05-10084)—A guide to Social Security survivors benefits
- *Social Security—SSI Benefits* (SSA Publication No. 05-11000) —A guide to the Supplemental Security Income proram

All of these publications, including this one, are available in Spanish.

In addition to *Your Medicare Handbook*, the Health Care Financing Administration publishes several leaflets of particular interest to Medicare beneficiaries. Among them are:

- *Guide to Health Insurance for People with Medicare* (Publication No. HCFA 02110)—A guide to how private health insurance supplements Medicare and some shopping hints for those looking at private supplements.
- *Medicare and Managed Care* (Publication No. HCFA 02195)—A guide to health maintenance organizations and other types of prepaid plans.

These publications are available from any Social Security office or by writing to Medicare Publications, Health Care Financing Administration, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

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